

Personal view

All doctors are disabled, but some are more disabled than others

I was asked to write this article because I went through medical school with a marked visible disability, which has given me a good ‘worm’s-eye’ perspective on how disability is handled within the medical profession.

Medicine is not an easy training. Most people who consider themselves fully able-bodied, seem to find it so challenging that they cannot imagine how anyone could cope with the training as well as an obvious handicap. This viewpoint constitutes one of the major handicaps facing disabled people wanting a career in medicine.

Experience is never wasted. The medical training is full of opportunities to learn about medicine, people, teamwork and relationships. During this training, each of us has to confront our individual weaknesses, and as all Deans know, some of us will come to the conclusion that our flaws are not consistent with our ambitions. I would like to encourage a more experimental attitude towards selection at undergraduate level. The training is not an all-or-nothing phenomenon, and it really isn’t a disaster if people do not travel smoothly along a conveyor belt towards consultant posts at the age of 32. I have a curriculum vitae peppered with holes and flaws. However, the end result has been a happy and fulfilling lifestyle.

Let us consider the three ages of medicine:

Infancy

Looking back at my training, most of the difficulties I faced were either unrelated, or only remotely connected to, my more obvious disabilities. They were difficulties I shared with many of my able-bodied peers, the worst of which were:

- social problems. I entered medical school with an inadequate infrastructure, a discretionary grant that periodically fell to pieces, and no idea that the course would require me to commute from the Middlesex to the Whittington, St Charles, the Eastman Dental, Welwyn Garden City and, at one point, Stourbridge! These difficulties were so overwhelming that I took a break, and worked for a while in a completely different job. I then returned to my studies, equipped with a driving licence, a car, a healthy wad of savings, and a beautiful stethoscope that was a parting gift from the people I had worked with while stashing away my funds. Sadly, there were other students who found the financial and practical hurdles insurmountable.
- information overload. Of course, as a house officer, one needs a lot of information at the back of one’s mind when examining patients. This essential mind library is, unfortunately, only the tip of the iceberg. We had to learn a lot of other facts as well, many of them we would never use again but which were somehow engraved in holy examination papers. You could argue, perhaps, that I had an organic dysmnnesia, but in that case there were an awful lot of other people suffering from this condition. It would perhaps be more sensible to divide examinations into basic and merit levels. Basic examinations must be passed by all medical students, and would contain core information of the sort needed at house-job level. Merit examinations would be available for students who wanted to document a particular interest in, say, anatomy, social medicine, or psychiatry.

- multiple choice examinations. You can know too little to pass an multiple choice examination; you can also know too much, or simply own a brain that doesn’t work in binary mode. There is nothing wrong with a brain that works like a computer, but neither is there anything wrong with a brain that makes more subtle distinctions. Multiple choice examinations are lazy examinations. Most people can alter their thought processes enough to scrape through them, but not all, and many of us found them a serious challenge.
- relationships and social life. I found myself ill-prepared for bridging the cultural and physical gaps between myself and the other students. Part of my difficulty was due to the physical barriers, but I am far from sure that this was the major problem. Again, an enforced break allowed me to grow up enough to cope more easily on my next attempt.

Compared with these difficulties, the physical aspects were not so troublesome. Partly, of course, this was due to the medical school administrative staff, who went to a lot of trouble to ensure that I was assigned to the ‘right’ firms. I know of other students who were not so lucky.

Childhood

I know of some disabled doctors who have fallen out with medicine during house jobs. When planning to deploy a disabled person in a house job, you have to bear in mind that the patients must come first. No patient should have to undergo even a simple phlebotomy at the hands of a doctor whose lack of dexterity exposes them to unnecessary pain and suffering. It isn’t easy to draw the line, and the lack of supervision of basic clinical skills means that only the most obvious cases get detected. I have seen patients suffer needlessly because of:

- unshakeable arrogance: one doctor was certain that he was doing a wonderful job, and if he couldn’t get the blood it was because there was no blood to be got. His technique was abysmal, and probably still is
- psychological problems: a doctor so immersed in her own misery that she was unable to offer her patients a smile of greeting or reassurance, and she really didn’t seem to care if she hurt them physically or emotionally
- substance abuse: a doctor whose hands shook badly and who smelt of alcohol in the mornings.

The other housemen come next. You can’t expect a group of struggling housemen to take on extra commitments because Dr Kahtan can’t run so she can’t carry a crash bleed. This sort of expectation may lead to resentment.

The disabled person comes next, and should be involved in careful planning of their house jobs. This is a very important formative year, and it is not enough to cobble together a couple of supernumerary jobs that will satisfy the General Medical Council. The Postgraduate Dean needs to find someone who has time and energy to think about the strengths and weaknesses, and potential career choices, of the disabled person.

Adulthood

If, by some whim of the Fates, you have got through your medical training without experiencing any sort of impairment, then you can be certain that you will have to cope

with disability during the course of your career. I don't want to depress anyone, but if I list a few hypothetical situations, you may see my point:

- a vascular surgeon develops presbyopia
- a cardiologist is appointed to a consultancy at 33 years of age and becomes profoundly depressed at the thought of doing this job for the next 32 years
- a surgeon's marriage breaks up under the strain of peculiar working hours and he gets seriously anxious and irritable in the operating theatre
- a general practitioner finds that she is developing some form of dementia or pseudo-dementia
- a pathologist suffers insidious deterioration in her vision, to a point at which she can no longer tell the difference between a dangerously malignant bone tumour and a completely benign condition.

Whether physical or psychological, most of us are going to have to cope with some problem that affects our performance at work. We can all call to mind tragic instances of how disabled doctors have put their patients at risk. Unfortunately, we as a profession have a tendency to assume that illness and disability happen to other people. We, the well, are treating them, the sick. We may therefore have problems in identifying one of our own profession as sick or

disabled. Until we change this attitude, these tragedies may evade detection, until too late.

Our patients do not need to see us as paragons of health and vitality. Most of them would rather know that we had some experience of being in their shoes. What is the point of trying to discuss your depression with someone who has no idea what you are talking about? In many cases, our weaknesses may also be our strengths.

Hence the title of this article. I would like every potential doctor to be viewed as a person, with a set of physical, psychological, and social, strengths and weaknesses. A creative and realistic look at these strengths and weaknesses would be far more productive than rough sorting into 'normal' and 'disabled' medical students. If this attitude were continued throughout the medical career, then I believe we could achieve major improvements in the health and welfare of our workforce, as well as that of our patients.

SUSANNAH KAHTAN

166 Hendon Way, London NW2 2NE, UK

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